MED - Policy Support Exception to Policy Review

Purpose: A member or provider who has non-covered items, pricing issues, received an adverse decision or who is requesting a service or an item which is outside of the current policy may request an exception to policy (ETP) by contacting the local Department of Human Services (DHS) office, by writing a letter to DHS Appeals Section or by filing on line at http://dhs.iowa.gov/appeals/exceptions_policy.

ETPs are requested for medical and dental procedures, medical equipment, home health, out of state nursing facility (NF) care, etc. Additionally, ETPs are requested for waiver services exceeding waiver rules. Medical services review staff provide adequate and timely information to DHS for consideration of ETP requests. Exceptions are granted at the discretion of DHS. DHS's denial of an exception is not appealable.

Identification of Roles:

Project Assistant and/or Review Assistant (RA) and/or Quality Improvement Facilitator (QIF) - assigns exception to policy requests in OnBase by entering keywords applicable to the request; the PA or RA forwards the ETP, via OnBase, to the appropriate QIF who will complete the review.

Performance Standards:

- Complete 95 percent of ETP reviews within 10 business days of receiving complete information required for the review.
- Complete 100 percent of ETP reviews within 20 business days of receiving complete information required for the review.

Path of Business Procedure:

Step 1: The project assistant or RA will review the exception to policy request in the MED02 logging queue in OnBase.
Step 2: The project assistant, RA and/or QIF will enter keywords.
Step 3: The project assistant, RA and/or QIF will double click the 'Enter Keywords' task on the right side of the screen and assign key words:

a. Exception number
b. Designated RA and/or QIF
c. Program Type
d. State identification (SID) number
e. Provider identification (ID)
f. Program types include:
    1. AIDS/HIV Waiver
    2. Ambulance
    3. Brain Injury Waiver
    4. Children's Mental Health Waiver
    5. Dental
    6. Durable Medical Equipment and /or Supplies

7. Drugs and/or Biologicals
8. Elderly Waiver
9. Enteral
10. HAB Services
11. Health and Disability Waiver
12. Home Health
13. Hospice
14. Intellectual Disability Waiver
15. Nursing Facility
16. Out-of-State
17. Physical Disability Waiver
18. PMIC
19. Procedure
20. Radiology
21. Surgical
22. Therapy
23. Vision

g. Check RECON if applicable
h. Check EPSDT if applicable
i. Check RUSH if applicable

Step 4: The PA, RA and/or QIF will forward the ETP in the OnBase workflow, to the MED 02 review queue for completion by designated QIF.

Forms/Reports:
N/A

Interfaces:
Data Warehouse
ISIS
MMIS
OnBase
MQUIDS

RFP Reference:
6.2
6.2.1.1
6.2.1.2
6.2.1.3

Attachments:
N/A

MED - Policy Support Exception to Policy Review Eligibility Verification

Purpose: Determination of eligibility prior to completing the exception to policy review

provides enhanced information to providers. Although each exception to policy will be reviewed for eligibility, approval does not guarantee that member will be eligible at time of services. Provider will access Eligibility Line Verification Service (ELVS) or web portal to verify eligibility at time of service.

Identification of Roles:

Quality Improvement Facilitator (QIF) – verifies eligibility of the member prior to using any tasks in OnBase.

Performance Standards:

- Complete 95 percent of ETP reviews within 10 business days of receiving complete information required for the review.
- Complete 100 percent of ETP reviews within 20 business days of receiving complete information required for the review.

Path of Business Procedure:

Step 1: Upon receipt of the ETP request in the MED02 review queue, the QIF will verify member eligibility.

Step 2: Log into Medicaid Management Information System (MMIS).

a. Application Number: Type 10 for recipient eligibility subsystem, press enter.
b. Recipient eligibility file
    1. Action Code: Type I for inquiry
    2. Member ID: Type member's SID press enter.
        a) Recipient Eligibility Display Screen 1 -Verify the following:
            1. Member name
            2. Legal name in MMIS matches name on PA form
            3. Date of birth
            4. Some PA types have service limitations based on age
            5. Third Party Liability TPL - IND
                i. If a V or Y is present see TPL resource file below
            6. Eligibility spans
            7. Fund codes
                i. Fund codes may be reviewed in greater detail by utilizing the DHS system coding instructions manual http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Master/14-B-App.pdf
        b) Recipient Eligibility Display Screen 2
            i. MEDICARE PART A and MEDICARE PART B ELIGIBILITY DATA
        c) Recipient Eligibility Display Screen 3 - LONG TERM CARE DATA
            1. Used to determine if member resides in a facility or is enrolled in waiver services.
            2. Patient liability used data

i. This is not used in determining eligibility for ETP press enter.

d) Recipient Eligibility Display Screen 4
   1. LOCK-IN DATA, MHAP DATA, IMSACP DATA
      i. This is not used in determining eligibility for ETP press enter.
e) Recipient Eligibility Display Screen 5
   1. HMO Data
      i. If the date span of Health Management Organization (HMO) includes the start date of the ETP request, the Program Manager for the ETP should be consulted.
   2. MediPASS data
      i. This does not affect ETP approval.
f) Recipient Eligibility Display Screen 6
   1. Guardian data
      i. This does not affect PA approval press page up
   2. Third Party Liability (TPL) Resource File
      i. Action Code: Type I for inquiry
      ii. Recipient ID: Type Member's SID, press enter.
g) TPL Resource Display Screen
   a. Verify coverage date spans
      i. F1 will access these additional pages.
      ii. TPL coverage types:
         1. 15 dental
         2. 02 basic medical
         3. 06 major
         4. 19 pharmacy
         5. 20 vision
h) Guardian Data
      i. This does not affect ETP approval
i) Recipient Service Limitations
      i. Action Code: Type I for Inquiry
      ii. Recipient ID: Type member's SID press enter
j) Recipient Eligibility Display Screen 9
      i. Recipient Service Limitations
         1. Audiology, Dental and Vision service information is noted here.

Step 3: If eligibility conflicts are noted, the QIF will contact the Program Manager for respective ETP type.

Forms/Reports:

N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2
6.2.1.1
6.2.1.2
6.2.1.3

MED – Policy Support Exception to Policy Review

Purpose: To provide review for medical necessity and cost reasonableness requests to exceed an established Medicaid policy or rule.

Identification of Roles:
Manager - tracks and reports performance standards, updates manual and completes reports.

Quality Improvement Facilitator – completes IQC process for peers within the ETP team.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Peer Reviewer (PR) – reviews medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:
- Complete 95 percent of ETP reviews within 10 business days of receiving complete information required for the review.
- Complete 100 percent of ETP reviews within 20 business days of receiving complete information required for the review.

Path of Business Procedure:
Step 1: Upon receipt of ETP in review queue, the QIF will review eligibility by member state identification number (SID).
Step 2: QIF will review all documentation submitted with the request for completeness.
Step 3: QIF will request via email, fax and/or phone call any additional information needed to conduct the review.

a. The first request for additional information will allow a timeline of five (5) business days for the information to be submitted;
b. If the additional information requested is not received within five (5) business days, a second request will be issued allowing two (2) additional business days.

Step 4: If additional information requested to complete the review has not been provided, the QIF will draft a letter denying the ETP request due to insufficient information provided to conduct a thorough review.
Step 5: If additional information has been provided, the QIF will review for medical necessity and cost appropriateness; the QIF may consult other business units in IME and/or the CAMD, MMD or other PR as needed.
Step 6: If financial verification of cost reports or projected cost reports are needed, the QIF will consult via email, with the Provider Cost Audit and Rate Setting Unit of IME to obtain the results of the cost report review to assist in the final ETP decision.
Step 7: If additional review is needed by the CAMD, MMD or PR is needed, the QIF will route the ETP request and supporting documentation via OnBase to the designated person; external PR utilizes mail or email to transmit documentation.
Step 8: The QIF will draft a letter outlining the recommendation for the request (approved, denied, dismissed, withdrawn) inclusive of pertinent information from the review to support the recommended decision.
Step 9: The QIF will submit draft of letter for IQC review by peers and manager.
Step 10: The QIF will post a copy of the drafted letter, approved via the IQC process, along with any additional information obtained through the review process which impacted the recommendation, to a shared folder stored at \\Dhsime\MEDICAL.772\LTCMCETP.
Step 11: The QIF will send email notification of completion of review to the assigned DHS Program Manager.

Forms/Reports:

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2
6.2.1.1
6.2.1.2
6.2.1.3

Attachments:
N/A

MED – Policy Support Exception to Policy Review Disruption of Business Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:

Project assistant (PA), Quality Improvement Facilitator (QIF) or Manager - assigns exception to policy requests and tracks in access database.

QIF - accesses documentation available from the Department of Inspections and Appeals via a shared folder on \\Dhsime\MEDICAL.772\LTCMCETP.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Peer Reviewer (PR) – reviews medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

- Complete 95 percent of ETP reviews within 10 business days of receiving complete information required for the review.
- Complete 100 percent of ETP reviews within 20 business days of receiving complete information required for the review.

Path of Business Procedure:

Step 1: Upon receipt of ETP in review queue, the QIF will review eligibility by member state identification number (SID).
Step 2: QIF will review all documentation submitted with the request for completeness.
Step 3: QIF will request via email, fax and/or phone call any additional information needed to conduct the review.

a. The first request for additional information will allow five (5) business days for the information to be submitted;
b. If the additional information requested is not received within five (5) business days, a second request will be issued allowing two (2) additional business days.

Step 4: If additional information requested to complete the review has not been provided, the QIF will draft a letter denying the ETP request due to insufficient information provided to conduct a thorough review.
Step 5: If additional information has been provided, the QIF will review for medical necessity and cost appropriateness; the QIF may consult other business units in IME and/or CAMD, MMD or other PR as needed.

Step 6: If financial verification of cost reports or projected cost reports are needed, the QIF will consult via email, with the Provider Cost Audit and Rate Setting Unit of IME to obtain the results of the cost report review to assist in the final ETP decision.
Step 7: If additional review is needed by the CAMD, MMD, or other PR is needed, the QIF will route the ETP request and supporting documentation via paper copy to the designated person; external PR utilizes mail or email to transmit documentation.
Step 8: The QIF will draft a letter outlining the recommendation for the request (approved, denied, dismissed, or withdrawn) inclusive of pertinent information from the review to support the recommended decision.
Step 9: The QIF will submit draft of letter for IQC review by peers and manager.
Step 10: The QIF will post a copy of the drafted letter, approved via the IQC process, along with any additional information obtained through the review process which impacted the recommendation, to a shared folder stored at \\Dhsime\MEDICAL.772\LTCMCETP.
Step 11: The QIF will send email notification of completion of review to the assigned DHS Program Manager.

Forms/Reports:

Interfaces:

RFP Reference:
6.2
6.2.1.1
6.2.1.2
6.2.1.3

Attachments:
N/A

MED - Policy Support Exception to Policy Review Reports

Purpose: To meet all performance standards and complete all required reports

Identification of Roles:
Manager - tracks and reports performance standards, updates manual and completes reports.

Performance Standards:
Provide the required reports within ten business days of the end of the reporting period (quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Procedure:

Step 1: The manager will track and report all performance standards in a format approved by DHS.
Step 2: The manager will implement monthly tracking measures.

a. Any problem trends will be addressed through process and/or workflow changes designed to reverse the trend and avoid a problem before it impacts a performance standard.

Step 3: Appropriate DHS Policy Staff who have completed security clearance will access the following reports for the ETP Program in Data Warehouse.
Step 4: The manager will access reports via OnBase.
Step 5: The manager will confirm completion of the ETP Timeliness tracking report by the designated QIF.
Step 6: Save completed report in IMEUniversal/MED SRV SUBMITTED REPORTS/ETP/FYyyyy, ETPTimeliness MM-YYYY.
Step 7: The manager will complete hard copy of Monthly PA Scorecard located in IMEUniversal/MED SRV SUBMITTED REPORTS/Administrative/Monthly Performance Measures/YYYY based on review of the above performance measures. Manager will provide designated Program Assistant with hard copy of monthly report.

Quarterly Reports
Step 1: The manager will complete a hard copy of the Med Srv Quarterly Overview located in IMEUniversal/ MED SRV SUBMITTED REPORTS/Administrative/Quarterly Narrative Document/YYYY.
Step 2: To complete the hard copy, manager will print previous quarterly narrative and make all changes needed on the hard copy and give to designated Project Assistant for completion.
Step 4: The manager will review completed error report. The IQC activities will be conducted monthly regarding inter-rater reliability in completing PAs.
Step 5: The QIF will send, via email, the completed IQC form.
Step 6: The manager will review all IQC forms and forward appropriate feedback to each QIF insuring that corrections are made in a timely manner.

Forms/Reports:

Interfaces:

Data Warehouse
MMIS
OnBase

RFP Reference:

6.2
6.2.1.1
6.2.1.2
6.2.1.3

Attachments:

N/A

MED- Policy Support - Appeals

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the Notice of Decision (NOD) letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at . The NOD letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings. Medical Services assists the Department in responding to appeals, provides written statements to support decisions, participates in appeal hearings as requested by the Department and provides administrative support in preparing for appeals.

Identification of Roles:

Review Coordinator (RC) – prepares initial draft of appeal summary, compiles appeal packet and information for testimony in appeal hearings.

Lead RC – assists with compilation of appeal packet, may provide testimony, may assist with team data tracking.

Project Assistant (PA) – retrieves appeals from DHS Appeals Information System (AIS) share, disseminates to IME vendor or Medical Services manager, logs appeal in access database and tracks outcome data.

Review Assistant (RA) or Project Assistant – disseminates packets and coordinates hearing date and time with the ALJ.

Manager – receives appeal requests from DHS, reviews appeal packets, may provide testimony. Designated manager compiles quarterly reports.

Medicaid Medical Director (MMD) – provides testimony for appeals.

Administrative Law Judge (ALJ) - presides over the appeal.

Performance Standards:

- Performance standards are not specified for this procedure

Path of Business Procedure:

Step 1: The PA receives an email appeal notice from DHS share coordinator.
Step 2: The PA logs into AIS (https://entaa.iowa.gov/entaa/sso?appId=DHSAPLIS&callingApp=http%253a%252f%252fsecureapp.dhs.state.ia.us%252fAppealsIS%252flogin.aspx%253fReturnUrl%253d%25252fappealsis%25252fhome.aspx#topHeader) to locate the appeal information using the appeal number given by the DHS.
Step 3: The PA records appeal activity on appeal database located on A:\Appeal Logs by entering the following:

a. Date Received
b. Date Issued
c. Appeal #
d. Member Name
e. Member SID
f. Unit Assigned
g. Type of Appeal
h. Assigned To
i. Policy Person Assigned

Step 4: The PA distributes appeal to representative of the appropriate team.
Step 5: The appellant may request a pre-hearing conference which will be indicated in the appeal notice. Upon receiving this request, the manager or designee will contact the appellant by telephone or email to obtain potential dates and times for the conference.
Step 5: The manager or designee will schedule the conference call and send notice to all parties involved. See MED – Administrative Functions – Collaboration, Community Based Resources and Referral Process for conference call procedures.
Step 6: The manager or designee will make any needed arrangements for interpreter or TDD. See MED – Administrative Functions – Health Literacy and Language/Telecommunications Device for the Deaf Line procedure.
Step 7: The pre-hearing conference is held. If new information is presented that may reverse the adverse decision, the team will discuss after the conference and pursue dismissal. *See Step 10*.

- If resolution was not achieved, the hearing proceeds. The manager or designee will take notes of the conference for the IME file.

Step 8: The RC or manager writes the case summary using standard templates specific to each program.
Step 9: If needed, the RC will request additional information from the provider, member or other appropriate source.
Step 10: If RC's review of the case or additional information indicates that the adverse decision can be reversed, the RC will proceed with obtaining necessary approval of services i.e., paying the claim, approving the prior authorization, or approving services in ISIS.
Step 11: The RC or manager composes a letter addressed to ALJ requesting dismissal of appeal.
Step 12: The RC or RA will send letter to member, ALJ, IM Worker, and other involved party, if applicable. The letter is sent by inter-office mail to DIA, ALJ, DHS policy staff and emailed to IM Worker and the Case Manager/Service Worker if one is assigned.
Step 13: If adverse decision is not reversed, the RC, RA or PA proceeds with completion of appeal packet.
Step 14: Appeal packet includes an appeal summary and exhibits of the member's medical information that was used by Medical Services in making the decision; program description, if applicable; Iowa Administrative Code (IAC) and/or Provider Manual references and/orcriteria used in the decision. Exhibits are labeled by alpha characters (Exhibit A, Exhibit B, etc) and each page numbered within the exhibit (A-1, A-2, B-1, B-2, etc).
Step 15: The RC or RA forwards completed packet to manager for review.
Step 16: After review, the manager forwards completed packet to RA to send to the Print

Shop for additional packets to be made or, produce at IME if the packet is small. The following are the steps to use the preferred Print Shop process:

a) Use Now Print software - login with email and assigned password. The manager has requested an account be set up for the IME user through the Print Manager at DAS.
b) Choose Start Order - Order Name is IME Appeal Number
c) Choose Grimes Copy Center
d) Choose Counter Drop-Off
e) Choose File Name - enter Appeal Number
f) Choose Description - enter appeal packets
g) Choose Page Size - enter Letter
h) Enter number of pages (include the colored paper between exhibits)
i) Choose Add Files
j) Choose Continue
k) Choose Print Options
l) Enter quantity (number of packets to be made)
m) Choose B & W, Single-Sided, 8.5 x 11
n) Choose Save
o) Choose date and time to return (usually allow 2 days)
p) Choose Continue
q) Write any special instructions (I am sending an appeal packet to the Grimes Copy Center for copying. Please make ^ (number) copies of the packet. Please copy all pages including the colored paper. Call ^ (name) at IME ^ (extension) when print order is boxed and ready for pickup at the Hoover building. Thanks.)
r) Choose Payment Type - enter Medical Services account number
s) Choose Place Order
t) Choose Back to Home - click on View Details and print 2 copies - 1 copy goes with the packet to the print shop and 1 copy is kept for your records

Step 17: The RA submitting the appeal to the Print Shop will receive an email from the Print Shop when the packets are completed. They are delivered to the RA's desk by the IME courier staff. The RA disseminates the packets to the member, ALJ, IMW and other involved parties if applicable.

- Packets are sent by interoffice mail to DIA ALJ and DHS policy staff.
- Packets for DIA should have DIA envelope attached directing appeal to head ALJ or her representative.
- Appeal summaries may be emailed to IM Workers.
- DIA requires that the appeal packet be distributed within 10 calendar days of the date on the Interoffice Memorandum giving notice of the appeal filing.
- DHS guidance suggests getting the packet to the appellant a minimum of five days prior to the hearing to give the appellant adequate time to review.

Step18: The PA receives scheduled hearing notice from DHS share coordinator.
Step 19: The PA logs it in the access database by entering the appeal hearing date and distributes to representative of appropriate team.
Step 20: The RA schedules hearing room and sends notices in Outlook and/or phone to attendees**.** Testimony provided by manager may be provided at the Manager's desk and room scheduling may not be needed.

Step 21: The RC, manager and/or MMD providing testimony receives the call from the ALJ for telephonic appeal hearing.
Step22: The appeal hearing is convened and conducted by the ALJ.
Step 23: Following the appeal, the PA receives appeal decision, logs the decision and notes, if applicable, in the Access Database and distributes decision to representative of appropriate team.
Step 24: Individual teams may also track appeal activity on spreadsheets to ensure their timely response to process requirements.
Step 25: If decision is affirmed no further action is needed.
Step 26: If decision is reversed, the manager reviews the decision to determine if a director review is warranted.
Step 27: The manager may consult with respective DHS policy specialist. If the DHS policy specialist approved proceeding with the request for Director's review, the manager composes a memo with the following elements:

a) Re: Recommendation for Review for Proposed Decision Appeal #.
b) Do not include new evidence that was not presented at the hearing.
c) Explain why the ALJ was incorrect.
d) Indicate policy specialist approval.
e) Attach the memo in PDF format along with the ALJ's proposed decision and send to DHS policy appeals committee representative.

This must be done promptly as the request must be submitted to the committee within 10 days of receipt of the decision.
Step 28: PA tracks direction decision requests and outcomes in access database.
Step 29: If the decision is not to pursue a director review, the RC proceeds with obtaining necessary approval of services i.e., paying the claim, approving the prior authorization, or approving services in ISIS.

Forms/Reports:

Pre-hearing conference letter

TO: name

FROM: Division of Medical Services, <Name, Title>

DATE: Date

SUBJECT: Pre Hearing Conference for members name

Appeal Number: MED number

You have requested a pre hearing conference for members name regarding a decision to not approve amount and type of service requested services. I have attempted to reach you by calling phone number without success.

Please call me at 515-XXX-XXXX or 1-800-383-1173 at your earliest convenience to arrange a time that will work with your schedule.

Sincerely,

<Name, Title>
Iowa Medicaid Enterprise- Medical Services Unit

cc:

Memorandum to request appeal dismissal

ATTENTION: ALJ's name OR Kristy Irwin, Administrative Law Judge

FROM: Division of Medical Services, <Name>

DATE: date

SUBJECT: Appeal Summary for members name, Appeal Number number

An appeal was filed for members name regarding denial of Waiver Prior Authorization type of service services provided on date of denial.

According to the Iowa Administrative Code number; authorization will be approved for type of service service when basis for medical necessity and services are medically necessary.

Upon review of documentation received from source of information on date, the Department has determined that type of service services are approvable. An approved notice of decision for members name is to be completed by the case manager. Based on the above information, the Department requests that the appeal be dismissed.

Thank you for your consideration in this matter. If you have any questions, please contact me at 515-XXX-XXXX.

Sincerely,

<Name, Title>
Medical Services, Iowa Medicaid Enterprise

cc: Name
street address
city, state zip code

CM name
Agency name
street address
city, state zip code

name, Income Maintenance Worker

Memorandum to request Director Review

DATE:
TO: XXXX, Appeals Advisory Committee
FROM: Iowa Medicaid Enterprise
RE: Recommendation for Review of Proposed Decision
Appeal XXXXXXXX

A proposed decision dated [DATE} has been filed by Administrative Law Judge [NAME}. This decision reverses the Department's decision to deny [MEMBER/PROVIDER AND SERVICE]. The Bureau recommends that the Proposed Decision issued on this appeal be reviewed.

We dispute this decision and assert that the IME, Medical Services Unit had the obligation to deny the request [DESCRIBE WHY THE ALJ WAS IN ERROR]. This denial in service was done in accordance with 441 IAC XXXXXX which is as follows:

441— [NUMERIC REFERENCE AND NAME]

Example: **78.43(5)** *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.
a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.
b. Only the following modifications are covered:
(16) Low-pile carpeting or slip-resistant flooring.

Per the proposed decision, Administrative Law Judge determined that [ALJ'S OPINION] In this case, the Department believes that [OUR OPINION]. Any approval of a request such as this should be made by the Director of the Department of Human Services under an exception to policy.

RFP Reference:
6.2.1.2

Interfaces:
Appeal Access Database

Attachments:
N/A

MED- Policy Support - Appeals Reports

Purpose: Data is reported quarterly on appeal activity.
Identification of Roles: Project Assistant (PA) – queries data from access database.

Manager – verifies accuracy of data and formats for quarterly reports.

Performance Standards:
Provide the required reports within 10 business days of the end of the reporting period (quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Procedure:

Step 1: The designated manager will complete a hard copy of the Med Srv Quarterly Overview located in IMEUniversal/Quarterly Progress Reports for the specific fiscal year.
Step 2: To complete the hard copy, manager will print previous quarterly narrative and make all changes needed on the hard copy and give to designated PA for completion.
Step 4: The PA will query the data from the access database including the following:

a) Appeals received
b) Decision rendered
c) Outcomes
d) Director review requested
e) Types of appeals

Step 4: The manager will provide complete and accurate data to the designated program specialist within required timeframes.

RFP Reference:

6.1.3.4.1
6.1.3.4.3

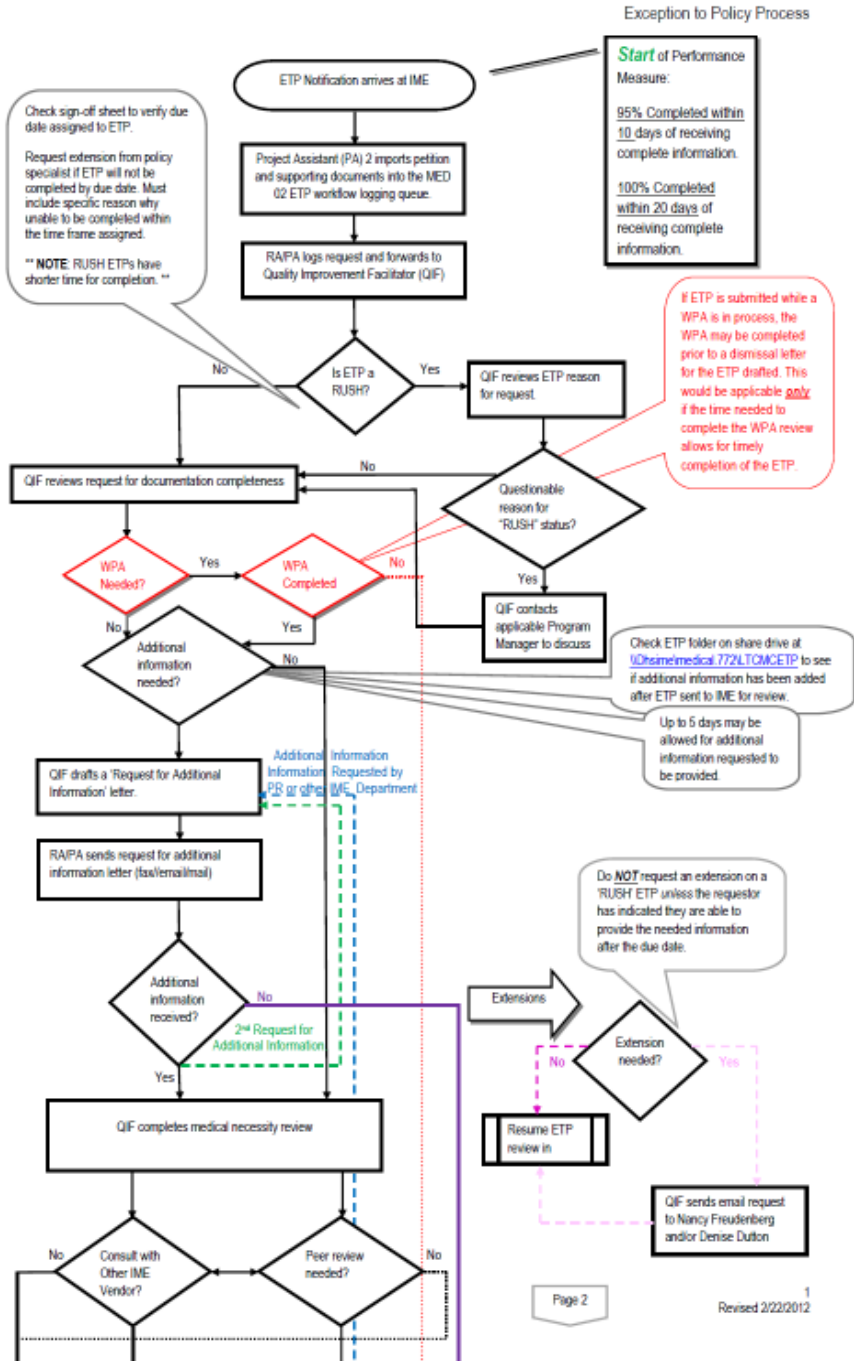
Interfaces:

Appeal Access Database

Attachments:

N/A

Attachment A:


Exception to Policy Process
Start of Performance Measure:
95% Completed within 10 days of receiving complete information.
100% Completed within 20 days of receiving complete information.
ETP Notification arrives at IME
Check sign-off sheet to verify due date assigned to ETP.
Request extension from policy specialist if ETP will not be completed by due date. Must include specific reason why unable to be completed within the time frame assigned.
** NOTE: RUSH ETPs have shorter time for completion. **
Project Assistant (PA) 2 imports petition and supporting documents into the MED 02 ETP workflow logging queue.
RA/PA logs request and forwards to Quality Improvement Facilitator (QIF)
Is ETP a RUSH?
No
Yes
QIF reviews ETP reason for request.
If ETP is submitted while a WPA is in process, the WPA may be completed prior to a dismissal letter for the ETP drafted. This would be applicable only if the time needed to complete the WPA review allows for timely completion of the ETP.
QIF reviews request for documentation completeness
Questionable reason for "RUSH" status?
WPA Needed?
WPA Completed
QIF contacts applicable Program Manager to discuss
Additional information needed?
Check ETP folder on share drive at \\Dhsme\medical 772\LTC\MCETP to see if additional information has been added after ETP sent to IME for review.
Up to 5 days may be allowed for additional information requested to be provided.
QIF drafts a 'Request for Additional Information' letter.
Additional Information Requested by PR or other IME Department
RA/PA sends request for additional information letter (fax/email/mail)
Do NOT request an extension on a 'RUSH' ETP unless the requestor has indicated they are able to provide the needed information after the due date.
Additional information received?
2nd Request for Additional Information
Extensions
Extension needed?
Resume ETP review in
QIF sends email request to Nancy Freudenberg and/or Denise Dutton
QIF completes medical necessity review
Consult with Other IME Vendor?
Peer review needed?
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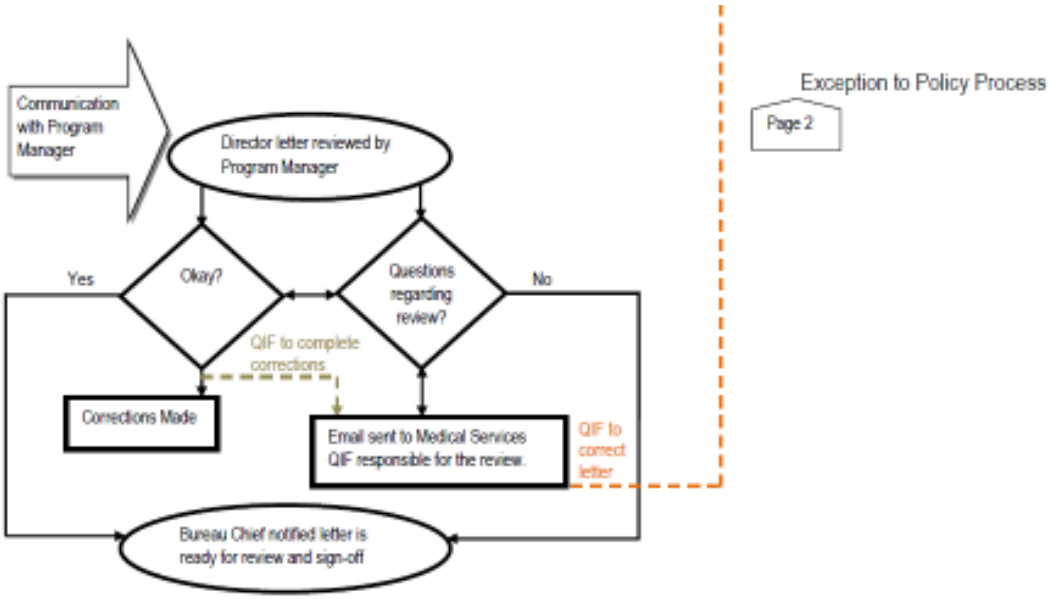
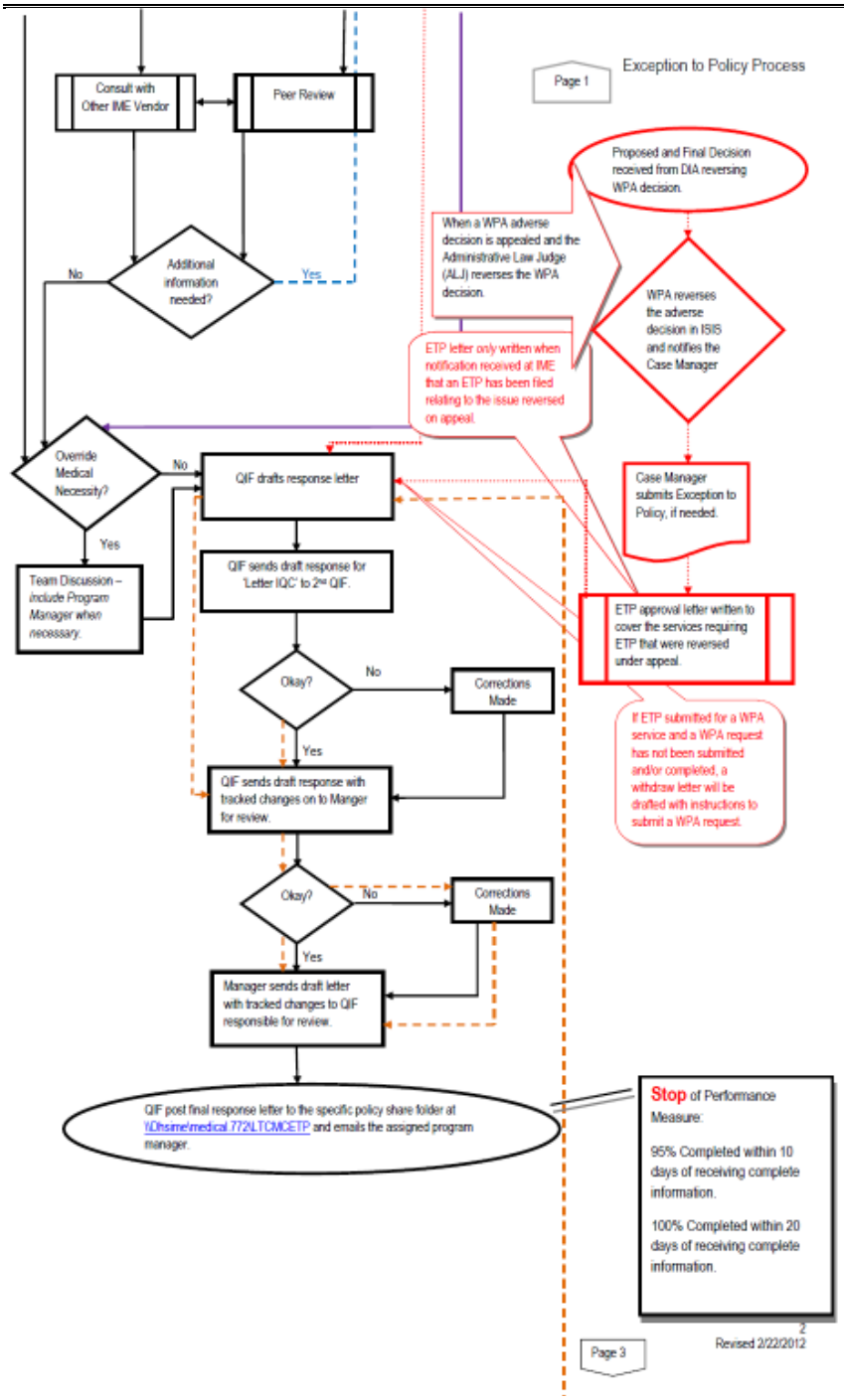
Revised 2/22/2012


Communication with Program Manager
Director letter reviewed by Program Manager
Okay?
Questions regarding review?
Yes
No
QIF to complete corrections
Corrections Made
Email sent to Medical Services QIF responsible for the review.
QIF to correct letter
Bureau Chief notified letter is ready for review and sign-off
Exception to Policy Process
Page 2


Exception to Policy Process
Page 1
Consult with Other IME Vendor
Peer Review
Additional information needed?
No
Yes
Override Medical Necessity?
No
Yes
Team Discussion – include Program Manager when necessary.
QIF drafts response letter
QIF sends draft response for 'Letter IQC' to 2nd QIF.
Okay?
No
Corrections Made
Yes
QIF sends draft response with tracked changes on to Manger for review.
Okay?
No
Corrections Made
Yes
Manager sends draft letter with tracked changes to QIF responsible for review.
QIF post final response letter to the specific policy share folder at \\Dhsme\medical 77\ALTC\MCETP and emails the assigned program manager.
When a WPA adverse decision is appealed and the Administrative Law Judge (ALJ) reverses the WPA decision.
ETP letter only written when notification received at IME that an ETP has been filed relating to the issue reversed on appeal.
Proposed and Final Decision received from DIA reversing WPA decision.
WPA reverses the adverse decision in ISIS and notifies the Case Manager
Case Manager submits Exception to Policy, if needed.
ETP approval letter written to cover the services requiring ETP that were reversed under appeal.
If ETP submitted for a WPA service and a WPA request has not been submitted and/or completed, a withdraw letter will be drafted with instructions to submit a WPA request.
Stop of Performance Measure:
95% Completed within 10 days of receiving complete information.
100% Completed within 20 days of receiving complete information.
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Revised 2/22/2012
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